

		FOR OHF USE				

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041731</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Provena St. Anne Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>4405 Highcrest Road</u> <u>Rockford</u> <u>61107</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Winnebago</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Michael R Gordon</u> (Title) <u>Vice President</u>																									
Telephone Number: <u>(815)299-1999</u> Fax # <u>(815)299-1560</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>																									
IDPA ID Number: <u>371127787010</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>10/6/86</u>																											
Type of Ownership: <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																									
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																									
	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																									
	<input type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
IRS Exemption Code <u>501c3</u>																											
In the event there are further questions about this report, please contact: Name: <u>Lynda Olinski</u> Telephone Number: <u>(708)478-7916</u>																											

STATE OF ILLINOIS

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Facility Name & ID Number Provena St. Anne Center# 0041731 Report Period Beginning: 1/1/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>59</u>	Intermediate (ICF)	<u>59</u>	<u>21,535</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>179</u>	TOTALS	<u>179</u>	<u>65,335</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>25,148</u>	<u>1,363</u>	<u>11,464</u>	<u>37,975</u>	8
9	SNF/PED					9
10	ICF		<u>22,033</u>		<u>22,033</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>25,148</u>	<u>23,396</u>	<u>11,464</u>	<u>60,008</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.85%

D. How many bed-hold days during this year were paid by Public Aid?

30 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/A - None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 10/6/1986

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 59 and days of care provided 11,464Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Provena St. Anne Center # 0041731 Report Period Beginning: 1/1/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	341,096	4,472	49,078	394,646		394,646		394,646		1
2	Food Purchase		284,919		284,919		284,919	2,665	287,584		2
3	Housekeeping	155,235	22,423	(276)	177,382		177,382		177,382		3
4	Laundry	31,502		136,718	168,220		168,220		168,220		4
5	Heat and Other Utilities			160,861	160,861		160,861	5,505	166,366		5
6	Maintenance	107,528	9,924	46,771	164,223		164,223	793	165,016		6
7	Other (specify):* Pastoral Care	80,133			80,133		80,133	(45,691)	34,442		7
8	TOTAL General Services	715,494	321,738	393,152	1,430,384		1,430,384	(36,728)	1,393,656		8
	B. Health Care and Programs										
9	Medical Director			1,705	1,705		1,705		1,705		9
10	Nursing and Medical Records	2,976,047	142,305	181,013	3,299,365		3,299,365		3,299,365		10
10a	Therapy			616,998	616,998		616,998		616,998		10a
11	Activities	99,490	174	788	100,452		100,452		100,452		11
12	Social Services	87,150		113	87,263		87,263		87,263		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,162,687	142,479	800,617	4,105,783		4,105,783		4,105,783		16
	C. General Administration										
17	Administrative	316,866	1,522	805,973	1,124,361		1,124,361	(413,939)	710,422		17
18	Directors Fees										18
19	Professional Services			204,795	204,795		204,795	14,554	219,349		19
20	Dues, Fees, Subscriptions & Promotions			41,189	41,189		41,189	(9,869)	31,320		20
21	Clerical & General Office Expenses		42,750	55,173	97,923		97,923	(16,400)	81,523		21
22	Employee Benefits & Payroll Taxes			1,071,214	1,071,214		1,071,214	56,472	1,127,686		22
23	Inservice Training & Education			4,907	4,907		4,907	8,236	13,143		23
24	Travel and Seminar			8,181	8,181		8,181	4,378	12,559		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			79,236	79,236		79,236		79,236		26
27	Other (specify):* Bad Debt			74,319	74,319		74,319	(74,319)			27
28	TOTAL General Administration	316,866	44,272	2,344,987	2,706,125		2,706,125	(430,887)	2,275,238		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,195,047	508,489	3,538,756	8,242,292		8,242,292	(467,615)	7,774,677		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number

Provena St. Anne Center

#0041731

Report Period Beginning:

1/1/03

Ending:

12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			341,770	341,770		341,770	(6,858)	334,912			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							203,276	203,276			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							16,052	16,052			34
35	Rent-Equipment & Vehicles			51,012	51,012		51,012	1,317	52,329			35
36	Other (specify):*											36
37	TOTAL Ownership			392,782	392,782		392,782	213,787	606,569			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			674,775	674,775		674,775		674,775			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,003	98,003		98,003		98,003			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			772,778	772,778		772,778		772,778			44
45	GRAND TOTAL COST											
	(sum of lines 29, 37 & 44)	4,195,047	508,489	4,704,316	9,407,852		9,407,852	(253,828)	9,154,024			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Provena St. Anne Center

0041731

Report Period Beginning:

1/1/03

Ending:

12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(95)	2		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(10,387)	30		9
10 Interest and Other Investment Income	(92)	32		10
11 Discounts, Allowances, Rebates & Refunds	(20,102)	21		11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(74,319)	27		24
25 Fund Raising, Advertising and Promotional	(17,109)	20		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule				29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (122,104)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(63,422)	VAR	34
35 Other- Attach Schedule	(68,302)	VAR	35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (131,724)		36
(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (253,828)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

Provena St. Anne Center

ID# 0041731

Report Period Beginning: 1/1/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Development Salaries	\$ (45,691)	7	1
2	Development Supplies	(1,160)	17	2
3	Development Activities	(305)	17	3
4	Development Misc - Net Assets Released	(15,481)	17	4
5	Development Supplies	(309)	21	5
6	Development Books	(26)	20	6
7	Development Benefits	(2,987)	21	7
8	Development Consulting	(900)	19	8
9	Development Travel	(1,443)	24	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(68,302)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena St. Anne Center# 0041731

Report Period Beginning:

1/1/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(95)	2,760	0	0	0	0	0	0	0	0	0	2,665	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	5,505	0	0	0	0	0	0	0	0	0	5,505	5
6	Maintenance	0	793	0	0	0	0	0	0	0	0	0	793	6
7	Other (specify):*	(45,691)	0	0	0	0	0	0	0	0	0	0	(45,691)	7
8	TOTAL General Services	(45,786)	9,058	0	0	0	0	0	0	0	0	0	(36,728)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(16,946)	(396,993)	0	0	0	0	0	0	0	0	0	(413,939)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(900)	15,454	0	0	0	0	0	0	0	0	0	14,554	19
20	Fees, Subscriptions & Promotions	(17,135)	7,266	0	0	0	0	0	0	0	0	0	(9,869)	20
21	Clerical & General Office Expenses	(23,398)	6,998	0	0	0	0	0	0	0	0	0	(16,400)	21
22	Employee Benefits & Payroll Taxes	0	56,472	0	0	0	0	0	0	0	0	0	56,472	22
23	Inservice Training & Education	0	8,236	0	0	0	0	0	0	0	0	0	8,236	23
24	Travel and Seminar	(1,443)	5,821	0	0	0	0	0	0	0	0	0	4,378	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(74,319)	0	0	0	0	0	0	0	0	0	0	(74,319)	27
28	TOTAL General Administration	(134,141)	(296,746)	0	0	0	0	0	0	0	0	0	(430,887)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(179,927)	(287,688)	0	0	0	0	0	0	0	0	0	(467,615)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena St. Anne Center# 0041731

Report Period Beginning:

1/1/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(10,387)	0	3,529	0	0	0	0	0	0	0	0	(6,858)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(92)	0	203,368	0	0	0	0	0	0	0	0	203,276	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	16,052	0	0	0	0	0	0	0	0	16,052	34
35	Rent-Equipment & Vehicles	0	0	1,317	0	0	0	0	0	0	0	0	1,317	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(10,479)	0	224,266	0	0	0	0	0	0	0	0	213,787	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(190,406)	(287,688)	224,266	0	0	0	0	0	0	0	0	(253,828)	45

Facility Name & ID Number **Provena St. Anne Center**# **0041731**

Report Period Beginning:

1/1/03

Ending:

12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2 Food Purchase	\$	Provena Senior Services	100.00%	\$ 2,760	\$ 2,760	1
2	V	3 Housekeeping - Supplies		Provena Senior Services	100.00%	0		2
3	V	5 Heat & Other Utilities		Provena Senior Services	100.00%	5,505	5,505	3
4	V	6 Maintenance - Other		Provena Senior Services	100.00%	793	793	4
5	V	17 Admin Salary Other Admin		Provena Senior Services	100.00%	188,716	188,716	5
6	V	17 Admin - Other	619,402	Provena Senior Services	100.00%	33,693	(585,709)	6
7	V	19 Professional Services		Provena Senior Services	100.00%	15,454	15,454	7
8	V	20 Dues, Fees, Subs & Promotions		Provena Senior Services	100.00%	7,266	7,266	8
9	V	21 Clerical/Genl Supplies		Provena Senior Services	100.00%	4,626	4,626	9
10	V	21 Clerical/Gen - Other		Provena Senior Services	100.00%	2,372	2,372	10
11	V	22 Emp Benefits & Payroll Taxes		Provena Senior Services	100.00%	56,472	56,472	11
12	V	23 Inservice Training & Education		Provena Senior Services	100.00%	8,236	8,236	12
13	V	24 Travel & Seminar		Provena Senior Services	100.00%	5,821	5,821	13
14	Total		\$ 619,402			\$ 331,714	\$ * (287,688)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Provena St. Anne Center

0041731

Report Period Beginning: 1/1/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	30 Depreciation	\$	Provena Senior Services	100.00%	\$ 3,529	\$ 3,529
16	V	32 Interest		Provena Senior Services	100.00%	203,368	203,368
17	V	34 Rent - Facility & Grounds		Provena Senior Services	100.00%	16,052	16,052
18	V	35 Rent - Equipment & Vehicles		Provena Senior Services	100.00%	1,317	1,317
19	V	17 Admin - Other	134,903	Provena Health	100.00%	134,903	
20	V	19 Professional Services	95,246	Provena Health	100.00%	95,246	
21	V	39 Ancillary Service Centers - Other	674,775	Provena Senior Services Pharmacy	100.00%	674,775	
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 904,924			\$ 1,129,190	\$ * 224,266

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Provena St. Anne Center # 0041731 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Provena St. Anne Center# 0041731 Report Period Beginning: 1/1/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Provena Senior Services
 Street Address 19065 Hickory Creek Drive, Ste 310
 City / State / Zip Code Mokena, IL 60448
 Phone Number (708) 478-7900
 Fax Number (708) 478-5387

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food Purchase	Mgmt Fee Income	5,373,327	16	\$ 23,945	\$ 619,402	\$ 2,760	1
2	3	Housekeeping - Supplies	Mgmt Fee Income	5,373,327	16	(3)	619,402	0	2
3	5	Heat & Other Utilities	Mgmt Fee Income	5,373,327	16	47,756	619,402	5,505	3
4	6	Maintenance - Other	Mgmt Fee Income	5,373,327	16	6,877	619,402	793	4
5	17	Admin Salary Other Admin	Mgmt Fee Income	5,373,327	16	1,637,117	619,402	188,716	5
6	17	Admin - Other	Mgmt Fee Income	5,373,327	16	292,291	619,402	33,693	6
7	19	Professional Services	Mgmt Fee Income	5,373,327	16	134,066	619,402	15,454	7
8	20	Dues, Fees, Subs & Promotions	Mgmt Fee Income	5,373,327	16	63,031	619,402	7,266	8
9	21	Clerical/Genl Supplies	Mgmt Fee Income	5,373,327	16	40,128	619,402	4,626	9
10	21	Clerical/Gen - Other	Mgmt Fee Income	5,373,327	16	20,574	619,402	2,372	10
11	22	Emp Benefits & Payroll Taxes	Mgmt Fee Income	5,373,327	16	489,898	619,402	56,472	11
12	23	Inservice Training & Education	Mgmt Fee Income	5,373,327	16	71,446	619,402	8,236	12
13	24	Travel & Seminar	Mgmt Fee Income	5,373,327	16	50,497	619,402	5,821	13
14	30	Depreciation	Mgmt Fee Income	5,373,327	16	30,618	619,402	3,529	14
15	32	Interest	Mgmt Fee Income	5,373,327	16	1,764,218	619,402	203,368	15
16	34	Rent - Facility & Grounds	Mgmt Fee Income	5,373,327	16	139,255	619,402	16,052	16
17	35	Rent - Equipment & Vehicles	Mgmt Fee Income	5,373,327	16	11,422	619,402	1,317	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 4,823,136	\$ 1,637,117	\$ 555,980	25

Facility Name & ID Number Provena St. Anne Center# 0041731

Report Period Beginning:

1/1/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Provena Health Services

Street Address

9223 West St. Francis Road

City / State / Zip Code

Frankfurt, IL 60423

Phone Number

(815)469-4888

Fax Number

(815)469-4864

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Admin - Other	Direct Allocation		\$	\$		\$ 134,903	1
2	19	Professional Services	Direct Allocation					95,246	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 230,149	25

Facility Name & ID Number Provena St. Anne Center# 0041731

Report Period Beginning:

1/1/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization

Provena Senior Services Pharmacy

Street Address

1475 Harvard Drive

City / State / Zip Code

Kankakee, IL 60901

Phone Number

(815)928-6141

Fax Number

(815)946-3238

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 674,775	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 674,775	25

Facility Name & ID Number Provena St. Anne Center# 0041731

Report Period Beginning:

1/1/03

Ending:

12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related							\$	\$			\$	9
	B. Non-Facility Related*												
10	Provena Senior Services											203,276	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related							\$	\$			\$ 203,276	14
15	TOTALS (line 9+line14)							\$	\$			\$ 203,276	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Provena St. Anne Center**# **0041731**Report Period Beginning: **1/1/03**

Ending:

12/31/03**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																												
1. Real Estate Tax accrual used on 2002 report.		\$	1																									
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																									
3. Under or (over) accrual (line 2 minus line 1).		\$	3																									
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																									
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																									
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																									
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																									
Real Estate Tax History:																												
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1998</td><td>8</td></tr> <tr><td>1999</td><td>9</td></tr> <tr><td>2000</td><td>10</td></tr> <tr><td>2001</td><td>11</td></tr> <tr><td>2002</td><td>12</td></tr> </table>	1998	8	1999	9	2000	10	2001	11	2002	12	<table border="1"> <tr> <td></td> <td>FOR OHF USE ONLY</td> <td></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2002 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>			FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2002 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
1998	8																											
1999	9																											
2000	10																											
2001	11																											
2002	12																											
	FOR OHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2002 \$	13																										
14	PLUS APPEAL COST FROM LINE 5 \$	14																										
15	LESS REFUND FROM LINE 6 \$	15																										
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																										

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Provena St. Anne Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0041731

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A.

Square Feet:

70,000

B.

General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

1

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facilty		1985	\$ 645,354	1
2					2
3	TOTALS			\$ 645,354	3

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Provena St. Anne Center

0041731

Report Period Beginning:

1/1/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	179		1993	\$ 2,722,251	\$ 100,483	25	\$ 100,483	\$	\$ 1,836,832
5			1986	3,516,907	90,742	25	90,742		944,480
6									
7									
8									
Improvement Type**									
9	VARIOUS		1987	3,173	127	20	127		2,030
10	VARIOUS		1990	36,288	1,122	20	1,122		16,652
11	VARIOUS		1991	30,799		20			30,799
12	VARIOUS		1992	10,277		20			10,277
13	VARIOUS		1993	8,128	406	20	406		8,128
14	VARIOUS		1994	7,032	703	20	703		6,680
15	VARIOUS		1995	43,992	2,376	20	2,376		20,007
16	VARIOUS		1996	27,087	2,221	20	2,221		19,562
17	VARIOUS		1997	92,025	3,775	20	3,775		74,070
18	VARIOUS		1998	54,564	5,424	20	5,424		54,564
19	VARIOUS		1999	20,128	3,822	20	3,822		17,917
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	DESC: GRATES FOR KITCHEN FLOOR SINKS (4)	2000	\$ 1,220	\$ 244	5	\$ 244	\$	\$ 854	37	
38	DESC: PAINT RESIDENT UNIT #D-31	2000	600	120	5	120		420	38	
39	DESC: REPAIR LEAK IN ROOF	2000	828	166	5	166		580	39	
40	DESC: HOT WATER HEATER (A O SMITH)	2000	4,950	495	10	495		1,733	40	
41	DESC: PAINT THERAPY ROOMS	2000	725	145	5	145		508	41	
42	DESC: PAINT D-35 RESIDENTS HOME ROOMS	2000	200	40	5	40		140	42	
43	DESC: SOAETH MIXING VALVES REPAIRS	2000	1,082	216	5	216		758	43	
44	DESC: PAINT BEAUTY SHOP & B-9 RESIDENTS WA	2000	555	111	5	111		389	44	
45	DESC: PAINT N-73 RESIDENTS WALLS	2000	225	45	5	45		158	45	
46	DESC: PAINT B-15 & B-11 RESIDENTS WALLS	2000	400	80	5	80		280	46	
47	DESC: CARPET FOR NUTRITION ROOM	2000	466	93	5	93		326	47	
48	DESC: REPAIR LEAK IN ROOM	2000	582	116	5	116		407	48	
49	DESC: REPAIRED LEAK IN HALL BY SWITCHBOARD	2000	474	95	5	95		332	49	
50	DESC: PAINT RESIDENT WALLS (G-61,B-10,C-26	2000	550	110	5	110		385	50	
51	DESC: PAINT A-8 RESIDENTS WALLS	2000	200	40	5	40		140	51	
52	DESC: PAINT RESIDENTS WALLS (G-67,F-50,F-5	2000	450	90	5	90		315	52	
53	DESC: PAINT RESIDENTS WALLS (F-58 & D-33)	2000	400	80	5	80		280	53	
54	DESC: PAINT D-29 & B-14 RESIDENT WALLS	2000	400	80	5	80		280	54	
55	DESC: DOOR ALARM "VOICE ANNOUNCE"	2000	5,723	1,145	5	1,145		4,006	55	
56	DESC: PAINT - 15 GAL	2000	246	49	5	49		172	56	
57	DESC: PAINT W-87 & NORTH WING NURSES STATI	2000	395	79	5	79		277	57	
58	DESC: PAINT A-5 & W-87 RESIDENTS WALLS	2000	225	45	5	45		158	58	
59	DESC: PAINT W-89 RESIDENTS WALLS	2000	200	40	5	40		140	59	
60	DESC: PAINT F-48 RESIDENTS WALLS	2000	200	40	5	40		140	60	
61	DESC: PAINT F-52 RESIDENTS WALLS	2000	200	40	5	40		140	61	
62	DESC: PAINT E-41 RESIDENTS WALLS	2000	200	40	5	40		140	62	
63	DESC: PAINT OFFICE WALL	2000	250	50	5	50		175	63	
64	DESC: PAINT NUTRIATION ROOMS	2000	338	68	5	68		237	64	
65	DESC: PAINT SOUTH & EAST NUTRITION ROOMS	2000	338	68	5	68		237	65	
66	DESC: REBUILD SOUTH WALL HYDRANT	2000	597	119	5	119		418	66	
67	DESC: FRONT LOBBY PROJECT	2000	3,462	692	5	692		2,423	67	
68									68	
69									69	
70	TOTAL (lines 4 thru 69)		\$ 6,599,329	\$ 216,042		\$ 216,042	\$	\$ 3,058,940	70	

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,599,329	\$ 216,042		\$ 216,042	\$	\$ 3,058,940	1
2	DESC: SAC COMMON AREA ASSESSMENT	2000	1,623	325	5	325		1,136	2
3	DESC: PAINT W99,C20,MEDICATION RM	2000	272	54	5	54		190	3
4	DESC: STEAMER UNIT REPAIRS	2000	1,245	249	5	249		871	4
5	DESC: UNIT 17 HVAC REPAIRS	2000	654	131	5	131		458	5
6	DESC: RGB MAJOR BUILDING CONSULTING	2000	5,712	571	10	571		1,999	6
7	DESC: CARPET - BEAUTY SHOP	2000	522	104	5	104		365	7
8	DESC: EMERGENCY QUAD RECEPTACLE	2000	557	111	5	111		390	8
9	DESC: PAINT HALL CEILINGS	2000	688	138	5	138		482	9
10	DESC: SMOKE DETECTOR & BASE	2000	505	101	5	101		354	10
11	DESC: MUSHROOM FLUORESCENT FIXTURES	2000	3,907	558	7	558		1,954	11
12	DESC: REPAIR HVAC #20	2000	844	169	5	169		591	12
13	DESC: RGB ARCHITECTURAL SERVICES	2000	1,198	240	5	240		838	13
14	DESC: RGB ARCHITECTURAL SERVICES	2000	521	104	5	104		365	14
15	DESC: RGB ARCHITECTURAL SERVICES	2000	4,037	807	5	807		2,826	15
16	DESC: PAINT RESIDENTS WALLS F49 & F51	2000	400	80	5	80		280	16
17	DESC: CARPET	2000	323	65	5	65		226	17
18	DESC: MUSHROOM FLUORESCENT FIXTURES (10)	2000	533	107	5	107		373	18
19	DESC: SIGNED REPAIRS	2000	1,053	211	5	211		737	19
20	DESC: PAINT RESIDENT WALLS F56 & C18	2000	400	80	5	80		280	20
21	DESC: PAINT CONFERENCE ROOM WALLS	2000	150	30	5	30		105	21
22	DESC: RGB ARCHITECTURAL SERVICES	2000	425	71	3	71		425	22
23	DESC: PAINT WALLS C-21 & C-24	2000	400	80	5	80		280	23
24	DESC: PAINT C-22 & C-27 RESIDENT WALLS	2000	400	80	5	80		280	24
25	DESC: PAINT RESIDENT WALLS	2000	875	175	5	175		613	25
26	DESC: RGB ARCHITECTURAL SERVICES	2000	964	193	5	193		674	26
27	DESC: WATER VALVES/NORTH WING	2000	626	125	5	125		438	27
28	DESC: DUPLEX RECEPTACLES (2) FOR LUNCH RM	2000	522	104	5	104		366	28
29	DESC: PAINT W-86,W-97,D-30 CARE PLAN OFFIC	2000	775	155	5	155		543	29
30	DESC: BURNER COANTROL, MIXED AIR MOTOR, ET	2000	2,067	413	5	413		1,447	30
31	DESC: DISCHARGE AIR SENSOR	2000	1,247	249	5	249		873	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,632,773	\$ 221,923		\$ 221,923	\$	\$ 3,079,698	34

**Improvement type must be detailed in order for the cost report to be considered complete

STATE OF ILLINOIS

Page 12C

Facility Name & ID Number Provena St. Anne Center

0041731

Report Period Beginning:

1/1/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,632,773	\$ 221,923		\$ 221,923		\$ 3,079,698	1
2	DESC: RGB ARCHITECTURAL SERVICES	2000	250	50	5	50		175	2
3	DESC: PAINT RESIDENT WALLS W-88	2000	200	40	5	40		140	3
4	DESC: PAINT OFFICE WALLS	2000	535	107	5	107		375	4
5									5
6	DESC: 3 WANDER GUARD SYSTEMS	2001	735	147	5	147		368	6
7	DESC: INSTALL NEW WATER SUPPLY LINES	2001	589	118	5	118		295	7
8	DESC: RECIRCULATING PUMP	2001	1,241	248	5	248		620	8
9	DESC: SOS POSTFORM CTOPS & LAMINATES	2001	1,110	159	7	159		397	9
10	DESC: WATER LINE REPAIRS	2001	1,115	223	5	223		557	10
11	DESC: "B" WING DOOR CONTROL	2001	1,595	319	5	319		798	11
12	DESC: THRU WALL UNITS & FILTERS	2001	9,245	1,849	5	1,849		4,623	12
13	DESC: ROOF REPAIRS	2001	1,636	327	5	327		818	13
14	DESC: PAINT SOCIAL SERVICE & PASTORAL CARE	2001	325	65	5	65		163	14
15	DESC: ROOF REPAIRS	2001	2,957	591	5	591		1,479	15
16	DESC: PAINT PINK FRAMES	2001	170	34	5	34		85	16
17	DESC: ROOFING REPAIRS	2001	796	159	5	159		398	17
18	DESC: SCANDROLI CONSTRUCTION - FRONT LOBBY	2001	26,011	2,601	10	2,601		6,503	18
19	DESC: FRONT LOBBY & MAIN ENTRANCE - ARCHIT	2001	1,637	164	10	164		409	19
20	DESC: TEMPORARY ENTRANCE - FRONT LOBBY	2001	832	166	5	166		416	20
21	DESC: EVAPORATOR ASSEMBLY FOR WALK-IN COOL	2001	1,783	357	5	357		892	21
22	DESC: MOTOR,RAIN SHIELD, ETC FOR COOLER/FR	2001	1,223	245	5	245		611	22
23	DESC: ROOFING REPAIRS	2001	458	92	5	92		229	23
24	DESC: PAINT N-WING WALLS	2001	565	113	5	113		283	24
25	DESC: FRONT LOBBY - WANDER GUARD SYSTEM	2001	140	35	2	35		140	25
26	DESC: ROOFING REPAIRS	2001	916	183	5	183		458	26
27	DESC: SCANDROLI CONSTRUCTION SERVICES - FR	2001	126,561	6,328	20	6,328		15,820	27
28	DESC: PAINT FOUND DIRECTOR OFFICE	2001	209	42	5	42		105	28
29	DESC: BLOWER ASSEMBLY (HVAC #21)	2001	868	174	5	174		434	29
30	DESC: CRANKCASE HEATER, BREAKER, MISC (FRE	2001	878	176	5	176		439	30
31	DESC: DRAIN/HEATER (WALK-IN FREEZER SYSTEM	2001	691	138	5	138		346	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,818,043	\$ 237,171		\$ 237,171		\$ 3,118,069	34

**Improvement type must be detailed in order for the cost report to be considered complete

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,818,043	\$ 237,171		\$ 237,171		\$ 3,118,069	1
2	DESC: MOTOR,CAPACITOR,ETC (WALK-IN COOLER/	2001	2,136	427	5	427		1,068	2
3	DESC: ROOFING REPAIRS	2001	717	143	5	143		359	3
4	DESC: PAINT WALLS (RESIDENT, BATH, REST)	2001	600	120	5	120		300	4
5	DESC: ROOF REPAIRS (SCUPPER)	2001	749	150	5	150		375	5
6	DESC: REACH-IN FREEZER REPAIRS	2001	661	220	3	220		551	6
7	DESC: REPLACE AIR COMPRESSOR-FIRE SPRINKLE	2001	3,524	705	5	705		1,762	7
8	DESC: SIMPLEX COMBINATION LOCK	2001	266	53	5	53		133	8
9	DESC: REPLACED PRESSURE CONTROL (COOLER)	2001	751	150	5	150		375	9
10	DESC: PAINT RESIDENTS WALLS (G62, G63 & G6	2001	600	120	5	120		300	10
11	DESC: NORTH HOT WATER HEATER MIXING VALVE	2001	1,424	285	5	285		712	11
12	DESC: WALK-IN FREEZER REPAIRS	2001	874	175	5	175		437	12
13	DESC: PAINT RESIDENT WALLS, DINING RM AREA	2001	660	132	5	132		330	13
14	DESC: HOT WATER PIPING	2001	694	139	5	139		347	14
15	DESC: WALK-IN FREEZER CONDENSER #24 REPAIR	2001	556	111	5	111		278	15
16	DESC: INSTALL FIRE ALARM - FRONT LOBBY	2001	14,772	2,954	5	2,954		7,386	16
17	DESC: PAINT RESIDENTS WALLS	2001	975	195	5	195		488	17
18	DESC: NORTON POWER TRACK HOLDER/CLOSER UNI	2001	557	111	5	111		279	18
19	DESC: BALLASTS (6) & CIRCUIT BREAKERS (2)	2001	614	123	5	123		307	19
20	DESC: FRONT LOBBY EXPANSION	2001	67,538	6,754	10	6,754		16,885	20
21	DESC: PAINT RESIDENT WALLS	2001	450	90	5	90		225	21
22	DESC: INSTALLATION OF SIGNS - LOBBY AREA	2001	693	139	5	139		347	22
23	DESC: NORTH WALK-IN COOLER REPAIRS	2001	2,460	492	5	492		1,230	23
24	DESC: REACH-IN FREEZER REPAIRS	2001	934	187	5	187		467	24
25	DESC: WALK-IN FREEZER REPAIRS	2001	846	169	5	169		423	25
26	DESC: TESTING ENGINEERS SERVICES	2001	470	94	5	94		235	26
27	DESC: INSTALL NEW WATER SUPPLY LINES - KIT	2001	1,056	264	4	264		660	27
28	DESC: REPLACED TOLIET & INSTALLATION	2001	652	130	5	130		326	28
29	DESC: PAINT RESIDENTS WALLS & WEST DINING	2001	510	102	5	102		255	29
30	DESC: BASEMENT DOOR HOLDERS (2)	2001	723	145	5	145		362	30
31	DESC: BLOWER WHEELS & BEARINGS (2) CHAPEL	2001	677	135	5	135		338	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,926,182	\$ 252,186		\$ 252,186		\$ 3,155,607	34

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward		\$ 6,926,182	\$ 252,186		\$ 252,186		\$ 3,155,607		1
2	DESC: HOT WATER REPAIRS NORTH WING	2001	909	182	5	182		455		2
3	DESC: THRU THE WALL AIR CONDITIONERS (S)	2001	4,550	910	5	910		2,275		3
4	DESC: ELECTRICAL WORK - NEW ENTRY ADDITION	2001	583	117	5	117		292		4
5	DESC: LOBBY IMPROVEMENTS	2001	8,927	893	10	893		2,232		5
6	DESC: LOBBY AREA SERVICES	2001	21,101	2,110	10	2,110		5,275		6
7	DESC: HAVC #1, #2, #18 REPAIRS	2001	2,005	401	5	401		1,003		7
8	DESC: HVAC #12 & HVAC #20 REPAIRS	2001	1,120	224	5	224		560		8
9	DESC: STEAMER REPAIRS	2001	2,062	412	5	412		1,031		9
10	DESC: TRASH RECEPTACLE, SAND TOP URN	2001	247	62	2	62		247		10
11	DESC: SEAL COATING OF FENCE IN PARK AREA B	2001	585	195	3	195		488		11
12	DESC: INSTALL NW DOOR INTERCOM	2001	1,186	237	5	237		593		12
13	DESC: COMPLETED SIGNED REPAIRS	2001	880	176	5	176		440		13
14	DESC: WEATHERPROOF KEY PAD & PROGRAMMED	2001	230	46	5	46		115		14
15	DESC: LOBBY & MAIN ENTRANCE	2001	9,049	905	10	905		2,262		15
16	DESC: RESET SYSTEM & FIX LEAK IN CAFE	2001	680	136	5	136		340		16
17	DESC: LANDSCAPE - NEW ENTRANCE	2001	1,271		1					17
18										18
19	DESC: PAINT WALLS - HANG WALLPAPER	2002	1,936	387	5	387		581		19
20	DESC: CANOPY FOR WEST UNIT	2002	3,760	251	15	251		376		20
21	DESC: WEST UNIT AWNING	2002	3,085	206	15	206		309		21
22	DESC: TAPESTRY FOR LOBBY	2002	850	170	5	170		255		22
23	DESC: PATIENT LIFT	2002	1,302	130	10	130		195		23
24	DESC: RENOVATION OF HALL AND CAFETERIA	2003	8,389	280	15	280		280		24
25	DESC: REPLACEMENT WATER HEATER	2003	4,600	230	10	230		230		25
26	DESC: WATER HEATER	2003	5,030	252	10	252		252		26
27	DESC: WATER HEATER REPAIR	2003	156	16	5	16		16		27
28	DESC: CONDENSING UNIT	2003	7,100	355	10	355		355		28
29	DESC: REPLACEMENT CARPETING FOR CHAPEL	2003	3,633	363	5	363		363		29
30	DESC: HURD WINDOWS	2003	3,540	177	10	177		177		30
31	DESC: MAINTENANCE FOR GENERATOR	2003	1,145	115	5	115		115		31
32	DESC: DIETARY BLOWER	2003	2,575	129	10	129		129		32
33	DESC: SALVAJOR DISPOSER	2003	2,219	111	10	111		111		33
34	TOTAL (lines 1 thru 33)		\$ 7,030,886	\$ 262,362		\$ 262,362		\$ 3,176,955		34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Provena St. Anne Center

0041731

Report Period Beginning:

1/1/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 502,743	\$ 64,645	\$ 64,645	\$	10	\$ 377,370	71
72	Current Year Purchases	45,130	3,555	3,555		10	3,555	72
73	Fully Depreciated Assets	279,334					279,334	73
74								74
75	TOTALS	\$ 827,207	\$ 68,200	\$ 68,200	\$		\$ 660,259	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transport	MINI-VAN	1998	\$ 43,500	\$ 4,350	\$ 4,350	\$	5	\$ 43,500	76
77	Maintenance	F150 FORD W SNOWPLOW	1999	23,172				3	23,172	77
78										78
79										79
80	TOTALS			\$ 66,672	\$ 4,350	\$ 4,350	\$		\$ 66,672	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,570,119	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 334,912	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 334,912	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,903,886	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocation - Home Office				16,052			5
6								6
7	TOTAL				\$ 16,052			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 52,329 Description: Nursing \$43,216, Activities \$235, Plant Eng \$877, Admin \$6,684, Home Office \$1,317

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2004 \$ _____

13. _____/2005 \$ _____

14. _____/2006 \$ _____

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a, 3	hrs	\$	5,412	\$ 282,488	\$	5,412	\$ 282,488	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		526	27,476		526	27,476	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		5,882	307,034	2,608	5,882	309,642	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				674,775		674,775	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	11,820	\$ 616,998	\$ 677,383	11,820	\$ 1,294,381	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,794,696	\$	1
2	Cash-Patient Deposits	77,816		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	10,376,541		3
4	Supply Inventory (priced at)	485,379		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,788		6
7	Other Prepaid Expenses	803,877		7
8	Accounts Receivable (owners or related parties)	251,746		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 20,809,843	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,263,715		12
13	Land	6,877,199		13
14	Buildings, at Historical Cost	72,927,547		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	13,543,467		16
17	Accumulated Depreciation (book methods)	(39,708,360)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	38,281		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Goodwill</u>	147,576		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 61,089,425	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 81,899,268	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,893,009	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,831,666		28
29	Short-Term Notes Payable	1,152,937		29
30	Accrued Salaries Payable	2,954,499		30
31	Accrued Taxes Payable (excluding real estate taxes)	123,166		31
32	Accrued Real Estate Taxes(Sch.IX-B)	320,867		32
33	Accrued Interest Payable	24,581		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Party</u>	50,095		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,350,820	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	41,981,938		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	102,004		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 42,083,942	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 50,434,762	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 31,464,506	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 81,899,268	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 83,092,773	1
2	Restatements (describe):		2
3	2002 Goodwill Write off per Audit	(3,481,389)	3
4	Adj. To Reconcile Consolidated Equity and Consolidated		4
5	Net Income to Nursing Facility Amounts	(48,800,472)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 30,810,912	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	653,594	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 653,594	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 31,464,506	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,199,235	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,199,235	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,164,347	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,164,347	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	5,774	13
14	Non-Patient Meals	95	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	641,179	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 647,048	23
	D. Non-Operating Revenue		
24	Contributions	22,762	24
25	Interest and Other Investment Income***	91	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,853	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	20,102	28
28a	Misc. Income	7,861	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 27,963	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,061,446	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,430,384	31
32	Health Care	4,105,783	32
33	General Administration	2,706,125	33
	B. Capital Expense		
34	Ownership	392,782	34
	C. Ancillary Expense		
35	Special Cost Centers	674,775	35
36	Provider Participation Fee	98,003	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,407,852	40
41	Income before Income Taxes (line 30 minus line 40)**	653,594	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 653,594	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Provena St. Anne Center

0041731

Report Period Beginning: 1/1/03

Ending:

12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,976	2,080	\$ 87,908	\$ 42.26	1
2	Assistant Director of Nursing	1,984	2,080	67,122	32.27	2
3	Registered Nurses	20,109	22,187	480,643	21.66	3
4	Licensed Practical Nurses	39,822	42,709	822,059	19.25	4
5	Nurse Aides & Orderlies	118,406	128,706	1,413,207	10.98	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,533	8,052	105,108	13.05	8
9	Activity Director	680	720	11,030	15.32	9
10	Activity Assistants	8,033	8,844	88,460	10.00	10
11	Social Service Workers	5,865	6,310	87,150	13.81	11
12	Dietician					12
13	Food Service Supervisor	3,696	4,160	69,472	16.70	13
14	Head Cook	8,525	9,138	106,146	11.62	14
15	Cook Helpers/Assistants	22,362	23,075	165,478	7.17	15
16	Dishwashers					16
17	Maintenance Workers	7,129	7,759	107,528	13.86	17
18	Housekeepers	16,926	18,467	155,235	8.41	18
19	Laundry	3,710	4,085	31,502	7.71	19
20	Administrator	1,832	2,080	110,810	53.27	20
21	Assistant Administrator	1,816	2,080	51,773	24.89	21
22	Other Administrative	5,074	5,482	78,415	14.30	22
23	Office Manager					23
24	Clerical	6,346	6,919	75,868	10.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Pastoral Care/Dev	3,077	3,679	80,133	21.78	33
34	TOTAL (lines 1 - 33)	284,901	308,612	\$ 4,195,047 *	\$ 13.59	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	324	\$ 23,968		35
36	Medical Director	\$75/mth	1,705		36
37	Medical Records Consultant	23	1,165		37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,733		44
45	Social Service Consultant	6	369		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	401	\$ 29,940		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	416	\$ 16,631		50
51	Licensed Practical Nurses	2,144	70,337		51
52	Nurse Aides	12	289		52
53	TOTAL (lines 50 - 52)	2,572	\$ 87,257		53

Facility Name & ID Number **Provena St. Anne Center**

STATE OF ILLINOIS

0041731

Page 21

Report Period Beginning: **1/1/03**

Ending: **12/31/03**

XIX. SUPPORT SCHEDULES

<p>A. Administrative Salaries</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 30%;">Name</th> <th style="width: 10%;">Function</th> <th style="width: 10%;">Ownership %</th> <th style="width: 10%;">Amount</th> </tr> <tr> <td>Judy Larson</td> <td>Administrator</td> <td></td> <td style="text-align: right;">\$ 110,810</td> </tr> <tr> <td>Other</td> <td>Other Admin</td> <td></td> <td style="text-align: right;">206,056</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td style="text-align: right;">\$ 316,866</td> </tr> </table> <p>B. 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Professional Services</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 30%;">Vendor/Payee</th> <th style="width: 10%;">Type</th> <th style="width: 10%;">Amount</th> </tr> <tr> <td>Legal Fees</td> <td>Various</td> <td style="text-align: right;">\$ 100</td> </tr> <tr> <td>Consulting</td> <td>Various</td> <td style="text-align: right;">1,166</td> </tr> <tr> <td>Consulting</td> <td>Various</td> <td style="text-align: right;">2,733</td> </tr> <tr> <td>Consulting</td> <td>Various</td> <td style="text-align: right;">369</td> </tr> <tr> <td>Consulting</td> <td>Various</td> <td style="text-align: right;">23,967</td> </tr> <tr> <td>Consulting</td> <td>Various</td> <td style="text-align: right;">900</td> </tr> <tr> <td>Consulting</td> <td>Various</td> <td style="text-align: right;">50,418</td> </tr> <tr> <td>Consulting</td> <td>Various</td> <td style="text-align: right;">95,246</td> </tr> <tr> <td>Purchased Services</td> <td>Various</td> <td style="text-align: right;">6,202</td> </tr> <tr> <td>Purchased Services</td> <td>Various</td> <td style="text-align: right;">12,200</td> </tr> <tr> <td>Purchased Services</td> <td>Various</td> <td style="text-align: right;">11,494</td> </tr> <tr> <td colspan="2">TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)</td> <td style="text-align: right;">\$ 204,795</td> </tr> </table>	Name	Function	Ownership %	Amount	Judy Larson	Administrator		\$ 110,810	Other	Other Admin		206,056																	TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 316,866	Description	Amount	Corp Service Fee	\$ 134,903	Mgmt Fee	430,937	Mgmt Fee Interest	188,465	Miscellaneous	51,668	TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 805,973	Vendor/Payee	Type	Amount	Legal Fees	Various	\$ 100	Consulting	Various	1,166	Consulting	Various	2,733	Consulting	Various	369	Consulting	Various	23,967	Consulting	Various	900	Consulting	Various	50,418	Consulting	Various	95,246	Purchased Services	Various	6,202	Purchased Services	Various	12,200	Purchased Services	Various	11,494	TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)		\$ 204,795	<p>D. 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Out-of-State Travel	\$																																																																																																																																																																																										
In-State Travel	8,181																																																																																																																																																																																										
Seminar Expense																																																																																																																																																																																											
Home Office Allocation	5,821																																																																																																																																																																																										
Entertainment Expense	()																																																																																																																																																																																										
(agree to Sch. V, line 24, col. 8)																																																																																																																																																																																											
TOTAL	\$ 14,002																																																																																																																																																																																										

* Attach copy of IMRF notifications

**See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)**

[illegible]

Facility Name & ID Number Provena St. Anne Center

STATE OF ILLINOIS

0041731

Report Period Beginning:

1/1/03

Ending:

Page 23

12/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 7783 - Life Service Network
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 179
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 55,858 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 98,003
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ No Has any meal income been offset against related costs? Yes Indicate the amount. \$ 95
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. not issued yet
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Provena St. Anne Center
0041731
Attachment for Related Facilities
12/31/2003

Related Nursing Homes

<u>Facility Name</u>	<u>City</u>
Provena Our Lady of Victory	Bourbonnais
Provena Pine View Care Center	St. Charles
Provena Geneva Care Center	Geneva
Provena Cor Mariae Center	Rockford
Provena St. Joseph Center	Freeport
Provena McAuley Manor	Aurora
Provena St. Anne Center	Rockford
Provena Villa Franciscan	Joliet
Provena Heritage Village	Kankakee

Related Business Entities

<u>Facility Name</u>	<u>City</u>	<u>Notes</u>
Provena Clinics		Physician's Clinics
Provena Fortin Villa Learning Center	Bourbonnais	Childrens Center
Provena Fox Knoll	Aurora	Retirement Community
Provena Health	Frankfurt	Parent Company
Provena Home Care		Home Health
Provena Home Equipment		Home Equipment
Provena Hospice		Hospice
Provena Hospitals		Hospital
Provena Laverna Terrace	Avilla, IN	Independent Living
Provena Meadowview Lodge	Kankakee	Supportive Living
Provena Senior Services	Mokena	Management Company
Provena Senior Services Pharmacy	Kankakee	Pharmacy
Provena St. Joseph Adult Day Center	Freeport	Adult Day Care
Provena St. Mary's Adult Day Center	Kankakee	Adult Day Care
Provena St. Vincent	Freeport	Community Living
St. Anne's Place	Rockford	Independent Living

[illegible]

[illegible]